Chronic Prostatitis: A Psychosexual Approach

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• *"Chronic prostatitis" unaccompanied by signs of active inflammatory disease is a psychosexual disturbance, not a bacteriological disease. Prostate massage, local therapy, and antibiotic therapy are usually of no therapeutic value; a careful history and evalution of the background and good social and psychiatric counseling are the only effective and rational means by which this so called "prostatitis" is controllable.*

CHRONIC PROSTATITIS is a common condition and patients who have it are likely to go from one physician to another and to have months or years of treatment without lasting improvement.

A clinical characteristic is daily discharge of thin mucoid material from the urethral meatus, worse upon arising but often persisting throughout the day. It often stains the underclothing, and it seems to come and go without a definite causal relationship to daily events of any kind. Often there is mild dysuria, terminal dysuria, a feeling of incomplete urinary emptying, perineal, low lumbar, sacral, suprapubic, testicular or urethral ache, and innumerable vague symptoms referable to the sexual function. Often the disease lasts a year or more. A history of gonorrhea is not often associated with it.

The symptoms are most frequent in young unmarried men, and also in married men when their wives are pregnant and again during the menopause. There are numerous spontaneous improvements and unexplained relapses, often during a course of treatment. Usually the patient has had unimpressive response to prostatic massage, passage of sounds, urethral instillations, bladder irrigations, diathermy and sitz baths, and to the use of vaccines, sulfonamides, penicillin, streptomycin and other antibiotic drugs. Most patients with chronic prostatitis are unmarried and often it is possible to elicit a history of irregular sex habits, surreptitious sexual practices as based upon social mores, sexual indulgence alternating with abstinence, and intermittent copious consumption of liquor.

A thin, watery mucoid discharge flows spontaneously or is stripped easily from the urethra. The urethral meatus seems excoriated. The discharge contains leukocytes and all the various organisms usually to be found on the inner surface of the thigh, such as colon bacilli, staphylococci, streptococci, micrococci, pleomorphic organisms and yeasts. Cultured specimens of these organisms show inconclusive sensitivity reactions to antibiotic drugs. The prostate gland often is swollen, tense and tender, but not nodular. Light prostatic massage causes a copious amount of blue-white mucoid watery substance to flow from the meatus. This substance contains many leukocytes lying singly and in clumps, and it does not contain the normal prostatic fluid "lecithin bodies." Prostatic massage often brings about a temporary but noticeable remission of symptoms.

To be kept in mind, of course, in making a diagnosis are other prostatic conditions such as true venereal disease as well as the mild persistent temporary urethral discharge that may be present after adequate antibiotic therapy of gonorrhea. Also to be considered are urethritis caused by chemicals used in some prophylatic preparations, urethral allergic reaction (the author once observed such a reaction in a person sensitive to chocolate), the aftermath of wassail, and the elusive but much mentioned male trichomoniasis. Remote possibilities are urinary tract tuberculosis and other specific infections.

SEXUAL SYMPTOMS

In articles in the recent literature, nonspecific urethritis is persistently considered a local genital illness, although many of the investigators stress that sexual symptoms and aberrations are associated with the condition. McCrea[5] stressed focal infection, but noted that the patient has "marked mental depression and lack of interest and ambition; there is prostatorrhea plus weakness and exhaustion." Colby[3] said that "chronic prostatitis is frequently overlooked, there are sexual symptoms due to chronic prostatitis which are diminished sexual desire, poor erections, and premature ejaculation; the condition is incurable." Henline[2] observed that "failure to establish normal sexual hygiene may interfere with the improvement in chronic prostatitis infection; chronic prostatitis frequently is present in the patient presenting symptoms of sexual dysfunction; treatment should include all urologic study and necessary correction of abnormalities as well as the avoidance of irregular sexual habits and overindulgence." Ockerblad and Carlson[6] stated: "Lack of regular sexual activity in one accustomed to it

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may induce prostatitis. It is seen in husbands of pregnant women, and married Army and Navy inductees. The secretion in little lobules of the prostate act as a culture medium for the invading bacteria which usually arrive by way of the blood stream." However, they expressed belief that dealing with focal infection elsewhere was not often of value, and they did not think highly of the use of vaccines, intraprostatic injections and the like. They advise prostatic massage as the treatment. Herbut[4] said that the "predisposing causes of chronic prostatitis are sexual aberrations such as masturbation, overindulgence, withdrawal, sexual excitement, alcoholism, trauma, and constipation, while the precipitating causes are bacteria by direct extension or blood and lymph metastases."

Whereas the investigators cited above place the sexual dysfunction as an effect of prostatitis, the author interprets prostatitis as a result of the sexual problem. This question is of the utmost importance, for it determines the entire plan of treatment.

PSYCHIC ASPECTS

The conclusions in this presentation are based upon experience derived from a fairly active urologic practice, from 12 years of attendance in urology clinics, and from observation of patients as a urology consultant in the Los Angeles City Health Department venereal disease clinic for ten years. From reflection upon this experience, the following thesis was evolved.

"Chronic prostatitis" unaccompanied by signs of active inflammatory disease, characterized by mild prolonged discharge of thin watery material from the urethra, urinary frequency, mild dysuria, perineal, testicular, low lumbar and urethral ache and by inconclusive bacteriologic findings, and not responding to prolonged prostatic massage, intraurethral therapy, chemotherapy and antibiotic therapy, is not primarily an anatomical and not a bacteriological disease. It is a psychosexual disturbance. Only the correction of the fundamental underlying psychosexual disorder will cause prostatitis of this kind to subside.

The prostate gland is a conglomerate of 30 to 50 tubo-alveolar compound glands, spongelike in character, with about 16 to 32 ducts arising from within the depth of the gland and emptying into the urethra on each side. There is some periglandular smooth muscle, within the stroma, which may have a contractile emptying and expulsion role. The prostate capsule is a thick, dense nonexpansile envelope of tissue. Overstimulation, chronic edema and congestion of the prostate gland—with the swollen gland prevented from expanding by the unyielding capsule—give rise to dysuria, burning sensation upon urination, perineal and sacral backache, burning and discomfort radiating through the penile tip, the glans and the urethra and overflow discharge of prostatic and urethral fluid. The patient constantly "strips down" the urethra, especially in the morning and after each voiding, "to milk out the discharge." There is oversecretion, poor emptying of the prostate, congestion of the gland and mechanical trauma to the urethra. A constant feeling of guilt, feeling of insecurity, hurried ungratified sexual performance and incomplete emptying upon orgasm bring about a vicious cycle. The patient attempts to have several orgasms each time, is constantly in search of a perfect sexual partner, has furtive hurried intercourse, fear of being surprised, fear of an illicit pregnancy, fear of venereal disease, fear of inability to demonstrate virility and manhood. As a result, he makes minute and painstaking postcoital examination of the urethra, the meatus and the urethral discharge, carefully observes postdefecation urethral discharge, and pays exaggerated attention to normal urethral and genital sensations.

It is fascinating to see the change that occurs as the patient goes from the unmarried to the married state. He may have the same sexual partner as before, precisely the same anatomical conditions, the same sexual performance, the same frequency. In short, everything may be exactly as before—but the prostate symptoms disappear. Is it the social acceptance, the legality, the security, the lack or diminution of guilt feeling, that results from possession of a marriage license?

Clark and Treichler[1] showed experimentally that the prostate gland responds to emotional stimulation through the autonomic nervous system. Their studies showed that directly following a period of sexual excitement and emotional stress (produced by viewing pornographic movies) there was a sharp increase in acid phosphatase activity in the urine.

There is, of course, true infectious prostatitis, such as used to occur after gonorrheal urethritis in the days before antibiotics. Prostatitis of that type, however, has all the other abnormalities associated with inflammation, such as fever, leukocytosis and increased sedimentation rate, and complications such as epididymitis and metastatic infections. The organism must be, and usually is, quite virulent, in order to invade the prostate at all. Acute infective prostatitis, gonorrheal or nonspecific, usually responds fairly well to antibiotics. As the prostate gland is quite vascular, it is probable that when antibiotic agents are administered they infuse the prostate gland in adequate concentration. The stubborn resistance of so-called "chronic prostatitis" (and of the bacteria recoverable from secretions exuded in prostatitis of this kind) to all antibiotics, is sharp evidence that the disease is not one of bacterial or viral infection.

Intraprostatic injection of antibiotics and dyes, and the use of Trattner bags for medicating the posterior urethra, are quite discredited now. Application of phenol and silver nitrate on the mucosa of the prostatic urethra seems completely irrational. Urethral stricture is not especially important in the perpetuation of prostatitis, except by coincidence. The author has seen many Negroes, in whom urethral strictures are notoriously dense, who had stricture without prostatitis.

The leukocytes that are present in expressed prostatic secretion are usually not "pus cells"; they are present because of an engorgement and swelling of the gland. In prostatitis of this type (or, to coin a word, "prostatosis") the typical "lecithin bodies" disappear from the prostate secretion, no organisms can be found in Gram-stained specimens, and the amount of expressed secretion is surprisingly copious. To palpation the gland is soft, large, only mildly tender and not nodular; after some experience, it is possible to note a characteristic "feel" in a sexually traumatized prostate gland.

Most prostatitis is grossly overtreated and certainly greatly overemphasized. A "hands-off" attitude should be reiterated constantly to the patient. The benignancy of the condition must be emphasized. In addition to treatment aimed at psychiatric factors, to be elucidated in the report of a case in following paragraphs, prostate massage is advocated because it mechanically empties a swollen, distended, congested, throbbing psychically traumatized gland fairly adequately. Often, prostate massage will cause a still more copious discharge, but only temporarily.

REPORT OF A CASE

The patient, a man 32 years of age, was first observed in February 1949. He was referred by a proctologist and he said that he had had four rectal operations but he still had unilateral pain in the legs attributed to rectal disease. There was history of nonspecific urethritis in 1941, attributed to a "strain." In 1943 the patient received weekly prostate massage and irrigation for four months. In 1948, following "very intensive sexual intercourse" he was told that he had an "incipient prostate abscess," but no abnormality was observed cystoscopically or in excretory urograms. The patient said that for five weeks preceding examination by the author he had had sexual intercourse two or three times every other night, and that during that time he had had urinary burning, "pain in the point" and morning urethral discharge. Careful urologic study at that time showed no anatomical abnormalities. The author wrote to the referring physician: "The patient was told that constant introspection, stripping down of the urethra, and concern with normal phenomena created a circle of interest and concern over the genital organs. He was advised to practice sexual activities in moderation, to practice moderation in living and in all other things, and to leave the urethra alone."

The patient returned in November 1949, stating that he had had an active sex life but that he sustained indefinite urethral penile trauma four weeks before. Seven days previously he awakened to find that his hand "was crushing the penis," after that he had had burning and aching in the urethra. The prostate was engorged and the secretion contained many leukocytes, but no other abnormalities were noted. In March 1950, the patient returned again with the complaint of chronic discharge and urethral burning. In another city a physician had passed a sound and severe urosepsis occurred, requiring hospitalization and administration of streptomycin. He had severe urethral burning and discharge, he was taking chloramphenicol, sitz baths, triple bromides nightly because of constant erections and nightly nocturnal emissions, and he awakened every morning with a painful erection.

In April 1950, he returned with complaint of "tremendous erections" all through the night every night, even though he was having sexual intercourse at least twice nightly. He said he changed girls weekly. Constant preoccupation with his genitalia and urinary tract interfered seriously with his making a living. As a palliative measure, large doses of stilbestrol (which the patient promptly dubbed "gopher balls") were given until he was taking 40 mg. twice daily. Engorgement and pain in the breasts developed, but the patient said that for the first time in a year he had some respite from genital discomfort. In the summer of 1950 a careful study was made of the patient, including thorough urologic examination, and no organic abnormality was noted. However, the patient returned 26 times from April 1950 to April 1951 for consultation and emotional ventilation, even though his frequent visits were discouraged.

During that time he was referred to another urologist for study, but the same diagnosis of "nonspecific prostatitis" was returned. In June 1951, he began to "go steady" with an attractive divorcee a little older than he, and far better educated. From that time on she was his only sexual partner. He decreased the stilbestrol dosage to a minimum, and had intercourse almost nightly—at least twice each time, but often even more in 24 hours. At this time he began to reveal to the author in great detail his childhood insecurity, his resentments toward his mother and especially toward his righteous and domineering father. From the latter, he had never received recognition as a grown-up, and he always was made to feel inadequate, unwanted and unrecognized. (The author had heard elsewhere that his brothers always considered him incompetent—although now he was making much more money than they.) He always wanted a girl who would both respect and mother him, and in whom he could find the happiness he never had in his boyhood. At this time the patient still had myriad urologic complaints, although they were considerably lessened.

The prostate secretion was copious and contained many leukocytes. There was constant urethral dripping.

He was married in November 1951. Two weeks later his visits ceased. He returned in four months only because he wished to know whether his fertility had been impaired by the massive amount of stilbestrol he had ingested. Incidentally, it had not. Reexamination at this time showed complete absence of urethral discharge, and a microscopically normal prostatic secretion. Instead of an apprehensive pinched-looking person he had become a confident handsome young executive. The author saw him nine times thereafter, chiefly to satisfy scientific curiosity. No urologic abnormalities were noted during that time.

The patient's wife became pregnant in January 1953 and, because of nausea and abdominal pain, she began to avoid intercourse. In March 1953, the patient returned with fullblown nonspecific prostatitis, severe dysuria and constant painful erections. He complained that his wife was beginning to behave toward him in a manner similar to that of his mother and father years before.

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